Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELLEN LEONARD, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-1273-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY TOTAL AMOUNT DUE EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SENT."

Amount in Dispute: $665.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary : A copy of dispute was placed in carrier rep box on December 30, 2010 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2010	99456-W5-WP and 99080-73	$665.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 01, 2010
   - 214 – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Services denied. Please contact the SRS Claims Examiner regarding these charges.

   Explanation of benefits dated September 22, 2010
   - W1 – Workers' Compensation State Fee Schedule Adjustment.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

   Explanation of benefits dated October 13, 2010
   - W1 – Workers' Compensation State Fee Schedule Adjustment.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 18 – Duplicate claim/service.

Issues

1. Has the compensability issue been resolved?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is CPT code 99080-73 included in the payment for the Return to Work (RTW) examination?
4. Is the requestor entitled to additional reimbursement?

Findings

1. On the first EOB dated September 01, 2010, the respondent denied reimbursement based upon "214 – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment." This denial reason was not supported upon reconsideration; therefore, the disputed services will be reviewed.
2. The provider billed the amount of $650.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(C)(ii)(II)(a)(b), the MAR is $300.00 for the musculoskeletal range of motion (ROM) on the wrists (upper extremities). The combined MAR for the MMI/IR services rendered is $650.00. The respondent paid $500.00.
3. 28 Texas Administrative Code §134.204(k) states that the RTW reimbursement "shall include Division-required reports". Therefore, reimbursement is bundled and no separate reimbursement is due.
4. Per the review of submitted documentation, the Division finds that additional reimbursement is due for CPT code 99456-W5-WP only.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 20, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.